HOUSE BILL No. 1623

DIGEST OF INTRODUCED BILL

Citations Affected: None (noncode).

Synopsis: Medicaid waiver claims and ICLB approval. Requires the office of Medicaid policy and planning to waive the filing deadline for resubmission of Medicaid claims submitted by a provider of Medicaid waiver services and group home services that merged with or acquired another Medicaid waiver provider or that was acquired by another provider of Medicaid waiver services in a change of ownership transaction. Requires the bureau of developmental disabilities services (bureau) to approve and pay claims for services provided under individual community living budgets (ICLBs) that were denied because the ICLB had not been approved or denied by the central office of the bureau and had been previously signed by the district office of the bureau.

Effective: Upon passage.

Becker, Brown C, Budak

January 19, 2005, read first time and referred to Committee on Public Health.

Introduced

First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

HOUSE BILL No. 1623

A BILL FOR AN ACT concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "provider of Medicaid waiver services" means either of the following:**

(1) An organization providing Medicaid waiver services to developmentally disabled individuals that after December 31, 1997, acquired or merged with another organization providing Medicaid waiver services to developmentally disabled individuals.

(2) An organization providing Medicaid waiver services to developmentally disabled individuals that after December 31, 1997, was acquired by or merged with another organization providing Medicaid waiver services to developmentally disabled individuals.

(b) Notwithstanding 405 IAC 1-1-3(b), Chapter 10, Section 5 of the Indiana Health Coverage Programs Provider Manual, or any other statute, rule, or policy, the office of Medicaid policy and planning established by IC 12-8-6-1 shall waive the time limits for resubmission of a waiver or group home claim:

(1) that was submitted by a provider of Medicaid waiver services or group home services within the Centers for Medicare and Medicaid Services federal time limit required by 42 CFR 447.45(d) for dates of service after December 31, 1997, and before January 1, 2004;

(2) for which payment has been denied because the claim was not resubmitted within the time limits in 405 IAC 1-1-3(b), Chapter 10, Section 5 of the Indiana Health Coverage Programs Provider Manual, or any other statute, rule, or policy after the claim was denied; and

(3) for which a request for administrative review has been filed as of December 31, 2004.

(c) Not later than ninety (90) days after the effective date of this SECTION, all claims for a payment required by subsection (b) shall be:

(1) paid; or

(2) denied for a reason other than untimely submission.

(d) This SECTION expires December 31, 2005.

SECTION 2. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "bureau" refers to the bureau of developmental disabilities services established by IC 12-11-1.1-1.**

(b) The bureau may not deny payment for services provided under an individual community living budget (including an individual community living budget that resulted in incorrect payments to providers due to delays in the state system) because the individual community living budget has not been approved, if:

(1) the individual community living budget was completed by the provider under contract with the bureau and signed by the district office of the bureau;

(2) the individual community living budget has not been approved or denied by the central office of the bureau; and

(3) the provider timely filed a request for administrative review after payment was denied.

(c) All individual community living budgets described in subsection (b) for dates of service after December 31, 1997, and before December 31, 2004, shall be considered to be approved by the bureau.

(d) Not later than ninety (90) days after the effective date of this SECTION, all claims for a payment required by subsection (b) shall be:

(1) paid; or

(2) denied for a reason other than failure of the central office

of the bureau to act on the individual community living budget.

(e) This SECTION expires December 31, 2005.

SECTION 3. **An emergency is declared for this act.**